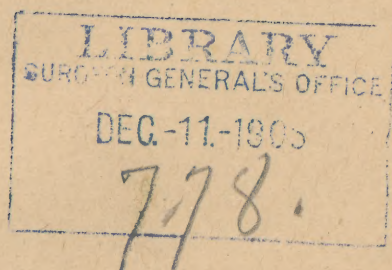
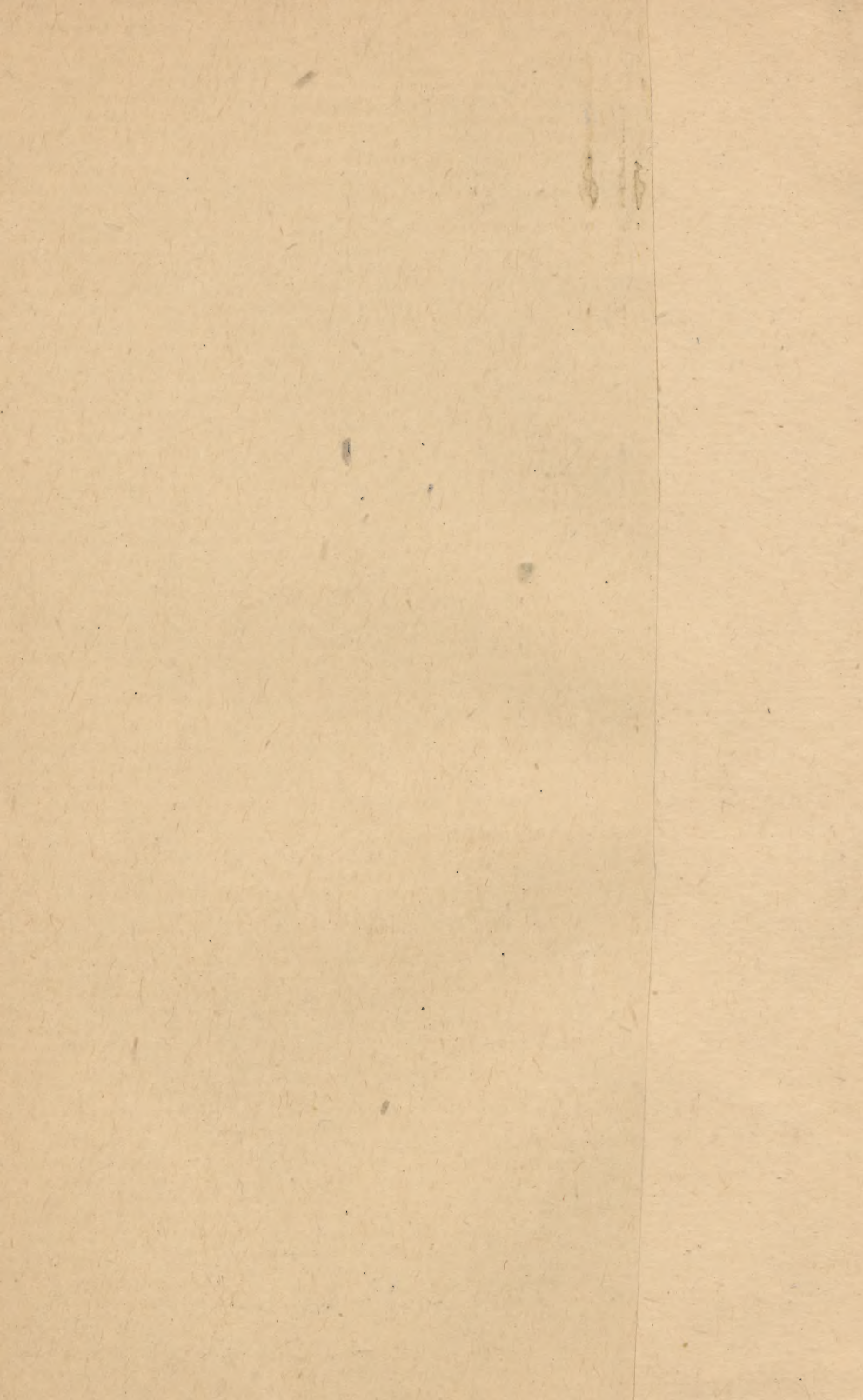


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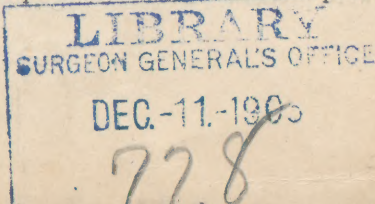
A CASE OF TUBERCULAR PERITONITIS WITH ENCYSTED COLLECTION OF FLUID, SIMULA- TING OVARIAN CYST.

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Montreal General Hospital.

S. B., æt. 23, unmarried, domestic servant, belonging to a remote country district north of the Ottawa River, who had lived in the city during the previous six months, was sent to me about last midwinter by my friend Dr. George Ross for examination, as the suspicion of pregnancy had arisen in consequence of extensive abdominal enlargement. She admitted a pregnancy terminating at six or seven months a year and a half previous. She could give no definite account of the date at or about which the present abdominal enlargement began, but her mistress noticed it three or four months previous. It had rapidly increased since then. The girl complained of abdominal pain; menses had been absent for three or four months; general strength, health and appetite had declined, and she had become emaciated. The tongue was red.

Examination.—The belly much enlarged; the skin below the navel presenting recent pinkish striæ, as well as old silvery streaks. Well-marked fluctuation over the whole of the anterior and antero-lateral aspects of the abdomen. Dullness on percussion over the same area. In the lumbar region (flanks) and epigastrium the bowel note present. No firm or solid part



to be felt anywhere. The anterior aspect of the abdomen quite uniform. The perineum slightly lacerated and the posterior vaginal wall partially prolapsed. The uterus, measuring two inches, pressed upwards and forwards, lay immediately behind the pubes. The patient was admitted to the Montreal General Hospital and kept under observation for a few days, when it was found that she had fever of septic type, the temperature at times running very high, with profuse sweating and occasional attacks of vomiting. During this interval she was seen by Drs. Fenwick, Ross, Roddick, Shepherd and J. C. Cameron, who concurred in my diagnosis of suppurating ovarian cyst. Another symptom, red blush and œdema of the central anterior part of the abdominal wall, seemed to support the view. Operation was resolved on, but delayed on account of the difficulty in communicating with the girl's relations, so far distant from the city.

Operation.—The ordinary incision for ovariectomy was made, but on reaching the peritoneum no separation of parietal from visceral layer could be made; the knife entered the collection of fluid, passing through what seemed to be a thickened, closely adherent cyst wall. The fluid was amber-colored, contained flakes, and in the last portions an obvious admixture of pus. The cyst wall did not collapse as the fluid escaped, but appeared to be adherent everywhere, even to the bottom of the pelvis. Acting on this view and with the concurrence of my friend Prof. Roddick, who was assisting, I decided to make no attempt at separation of the supposed cyst, but to drain and irrigate, as affording the patient the best chance. A large glass tube was passed through the wound into the Douglas pouch, and irrigation practised every two hours, night and day. At first weak carbolicized water, then corrosive sublimate solutions, and finally solutions of iodine, were used for this purpose. The general condition at once improved, and this was maintained for a period of ten days. Fever diminished and appetite improved. After a few days the reflux water during irrigation contained enormous quantities of fibrinous, flaky material. Soon, however, her condition again declined. Temperature ran high; sweats were profuse. The discharge always somewhat foetid, became

more so. Soon after the operation the patient suddenly developed a cough with expectoration, which soon became purulent, and was at times bloody. Three weeks after the operation a large rubber drainage-tube was passed through the Douglas pouch and out by the vagina, being carried a few inches beyond the vulva. This did no good. She gradually sank, and died exhausted six weeks after the operation. Two days before death she complained of sore throat, and on examination the fauces, tonsils and posterior wall of the pharynx were found to be covered with a diphtheritic membrane. Until the autopsy, I adhered to the original diagnosis of suppurating, universally adherent, ovarian cyst. Dr. R. J. B. Howard, acting pathologist to the Hospital, made the autopsy. I append his report:—"On opening abdomen a large globular mass presents, of the size of a man's head, occupying false pelvis; this and the parietes are everywhere covered by a grey, rough membrane about one-eighth of an inch thick. The transverse colon is firmly adherent to the upper surface, and is also bound tightly down to the liver. A collection of pus is found below and by the side of the spleen, and another, smaller, under left lobe of liver in middle line. The anterior peritoneal cavity is thus converted into a suppurating cyst, extending from liver down into true pelvis, nearly filled by the mass, which is found to consist of all the intestines, except the transverse colon, closely matted together by recent slight adhesions, which are studded with miliary tubercles. The cyst wall is apparently much older than the inter-intestinal adhesions, and looks like an unhealthy granulating membrane. The walls and viscera of true pelvis are covered by the same membrane. The great omentum has quite disappeared; but no doubt had been spread out over the intestines, and formed part of the membrane covering them. All the abdominal viscera adherent to one another and to parietes. Liver fatty; contains a few gray granulations. Kidneys contain a few gray granulations. Lungs universally adherent; abundantly studded with gray granulations. Tonsils and pharynx—surface gray and sloughy-looking. No loss of substance; same appearance involves œsophagus opposite cricoid cartilage, and about four inches lower down."

Remarks.—The principal interest of the case lies in the diagnosis. It well illustrates how difficult it may be to definitely fix the real nature of an abdominal fluctuating tumor. The fact that the abdominal enlargement was uniform, central, and occupying the anterior and antero-lateral parts of the abdomen, to the exclusion of the flanks, where the clear percussion note shewed the presence of bowel, added to the difficulties. A similar case occurred to my colleague, Dr. Fenwick, some years ago. The same error of diagnosis was made by all who saw the case. This patient died some months after operation, probably also of tuberculous disease, as she developed a pleuritic effusion before leaving the hospital. Other similar cases are reported by Spencer Wells, Erich, Ewing Mears and Atlee. The well-known dangers of tapping ovarian tumors, in my opinion, make that procedure for obtaining fluid for microscopical examination unjustifiable, especially as there is no concurrence of opinion of microscopists as to the certainty of that means of diagnosis. Happily, the treatment in my case leaves no room for regret, as under the circumstances it was the very best that could have been applied. It clearly prolonged life, and if the peritonitis had been simple it would almost to a certainty have saved the life of the patient.

